

7.0 Person Centered Planning Guidelines

7.1 Summary and Background

The State Plan: A Blueprint for Change establishes person centered planning as fundamental to system reform within the Division of MH/DD/SAS. In the past, regulatory standards have governed the process of treatment or support plan development. These standards drove the planning process through requirements on the types of assessments to be completed and the professionals to be involved. Person centered planning departs from this approach in that the individual with the disability assumes an informed and in-command role for life planning. Although all plans must be reviewed at least annually, as directed by Federal guidelines, the plan should be considered a living document that changes in response to individual need.

For a child, the plan and the planning process is comprehensive, inclusive of the family. Person-centered, family focused methods are a process for identifying life outcomes and strategies to support the achievements of the outcomes. Family members are essential to the planning process and its success.

The person centered planning process does not give full authority to do or provide anything desired. Instead, the process of person centered planning seeks to use a blend of natural and publicly sponsored specialty resources uniquely tailored to the individual or family needs and desires. The process accepts use of publicly sponsored specialty resources as the financing of last resort relative to an individual's plan.

Although the literature identifies specific methods for person centered planning these guidelines do not support one model over another. Specific identified models of person centered planning such as Individual Service Design, Personal Futures Planning, MAPS, Essential Lifestyle Planning, and Planning Alternative Tomorrows with Hope (PATH) are simply tools to more effectively complete the process of person centered planning. Wraparound is also a person-centered family-focused planning method that is typically used for children and families. However, all of the approaches share common themes and elements, which are further defined in these guidelines.

7.2 Values and Principles Underlying Person Centered Planning

The key values and principles serving as the foundation of person centered planning are as follows:

1. Person centered planning builds on the individual's/families strengths, gifts, skills, and contributions.
2. Person centered planning supports consumer empowerment, and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals and aspirations.
3. Person centered planning provides services and supports that meet the individuals immediate needs, as well as honor goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
4. Person centered planning supports a fair and equitable distribution of system resources.
5. Person centered planning processes create community connections. They encourage the use of natural supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community.
6. Person centered planning sees individuals in the context of their culture, ethnicity, religion, gender and sexuality. All the elements that compose a person's individuality are acknowledged and valued in the planning process.

7.3 Essential Elements

Person centered planning and plans shall adhere to the following essential elements:

1. Person centered planning begins with the identification of the reason the individual/family is requesting assistance. It focuses on the identification of the individuals/family's needs and desired life outcomes- not the request for a specific service. Life outcomes are defined across life domains-- housing, career/employment, education, relationships, finance (including entitlements and insurance), health, safety, transportation, spirituality, legal, civic, communication, cultural, emotional, as examples. A person centered plan does not need to address outcomes in each and every life domain, integrated strategies may cover more than a single life domain and different life domains may be covered at different time. Life outcomes to be pursued at any given time are directly related to priorities of the individual/family in relationship to life circumstances, situations and conditions as well as consideration of immediate needs and long term desires.
2. Person centered planning in an emergent situation first focuses on the individual's/family's immediate needs by providing services and/or supports to stabilize the crisis situation.
3. A person-centered process only occurs when the individual/family is involved in the process.
4. Gathering information to include in the person-centered plan can occur separately with the individual, family members, or others.
5. The person centered planning process encourages the involvement of family, friends and others, who are identified for participation by the consumer, in the planning process.
6. All information collected must be confirmed with the individual/family before documenting to insure accuracy. Information must be communicated to the individual/family in a way that they understand.
7. The health and safety needs of the individual are identified in partnership with the individual/family. Supports to maintain the individual's health and safety should be developed within the context of the individual's preferred lifestyle.
8. The process maintains a balance between rights, responsibilities, and risks experienced by all citizens.
9. Life outcomes should be prioritized by the individual/family.
10. The individual/family preferences and choices must be identified and, if not accepted and provided, there must be an appeals/dispute process to address and resolve disagreements and to ensure fairness and equity.
11. Potential support and/or treatment options to meet the goals and needs of the individual/family are identified and discussed with the individual/family.
12. The individual/family must be fully informed to make responsible choices based on the options presented.
13. Person centered planning develops and enhances the use of natural supports such as family, neighbors, co-workers, and friends whenever possible. Existing supports in the individual's life should be recognized and documented. Unexplored natural supports should be explored. This also includes the gifts, talents and resources the individual gifts
14. Opportunities to connect the individual to the community should be identified. This includes efforts to access and secure community resources as part of the strategies to support the individual's pursuit and achievement of plan related life outcomes.
15. Purchased or funded supports and services should augment as needed-- not supplant natural supports and community resources.
16. The planning process identifies crisis early warning signals, triggers and the necessary services and supports to ensure the health and safety of the

individual. It provides proactive as well as reactive planning and crisis contingencies that are aimed at averting diminished quality of life. Included within this planning process should be consideration of Advance Directive for Mental Health Treatment. NC law, GS 122C-77, Advance Directive for Mental Health Treatment, provides individuals with the opportunity for advance planning for a time in the future when a person may need treatment but is not capable of communicating or making treatment choices. Relapse prevention for individuals with substance abuse issues and plans for addressing challenging behaviors for individuals with developmental disabilities must also be included within the planning process.

17. The individual/family is provided with opportunities to refine and change the continually evolving plan as new opportunities arise or when significant changes occur.
18. Individuals are provided with ongoing opportunities to provide feedback about how they feel about the services and/or supports they are receiving and their progress toward achieving outcomes in specific life domains. The feedback is collected and changes are made in response to the feedback.

7.4 Procedure for the Initiation and Ongoing Development of the Person Centered Plan

All individuals in a target population and receiving enhanced benefits will have a fully developed person centered plan. Individuals only receiving services in the basic benefit and who are not part of a target population will participate in a limited person centered planning process. Nevertheless, regardless of whether the individual is receiving basic or enhanced benefits the process of planning must adhere to the values and principles of person centered planning. The health and safety and personal preferences of the individual are the primary consideration in the development of all plans.

7.4.1 Accessing the Person Centered Planning Process

Person centered planning begins when the individual/family makes a request to the system. The first step is to discover the reason for the individual/family request for assistance. A determination is made as to whether the issue is a MH/DD/SA issue, and if so, whether it is emergent, urgent, routine or other. During this initial screening and triage process, the focus is on the individual/family needs and valued outcomes rather than requests for specific services.

7.4.1.1 Emergent Issues

If the issue is emergent, there is an immediate connection made with the crisis response system. The timeline for the crisis response is immediate, and a crisis response is authorized by the triage or emergency service designated. The goal is to stabilize the crisis situation. Although in an emergent situation an individual's opportunity to make choices may be limited, the underlying values and principles of person centered planning are applicable. Once the individual is stabilized a provisional determination is made as to whether the individual is part of a target population and whether further assistance is needed. If the individual is determined to meet target population and needs MH/DD/SA Enhanced Benefits post crisis, a referral and linkage is made prior to discharge for initial services, inclusive of intake assessment, with a provider of choice. Intake assessment is automatically authorized to the consumer's provider of choice.

7.4.1.2 Urgent Issues

If the issue is urgent, the individual/family is provided information about qualified providers for initial services, inclusive of intake assessment, and makes a choice among providers. A referral and linkage for intake assessment is made within 48 hours and is automatically authorized to the provider of the consumer's choice. Most individuals within the target populations will receive a case management type model of practice; i.e. Community Support, ACT, DD Targeted CMgt. Following intake with the provider of choice, the primary clinician or case manager and the individual/family will have a pre-planning meeting for further plan development.

7.4.1.3 Routine Issues

If the issue is routine, the individual/family is provided information about qualified providers of initial services, inclusive of intake assessment, and makes a choice among providers. An appointment for intake assessment is made within 7 calendar days. The assessment is automatically authorized to the provider of the consumer's choice. Most individuals within the target populations will receive a case management type model of practice; i.e. Community Support, ACT, DD Targeted CSM. Following intake with the provider of choice, the primary clinician or case manager and the individual/family will have a pre-planning meeting for further plan development.

7.4.2 Person Centered Plan Authorization

In all situations, the first component of intake assessment will be to confirm target population status. If the individual is determined to be a part of a target population, a full diagnostic assessment is completed. It is at this point that the initial phase of the person-centered plan is developed based on information gathered during the assessment process. During this process the individual/family must state their desired outcome for the service. The primary clinician or case manager and the individual/family will then have a pre-planning meeting for further plan development. This process includes discussion regarding:

1. Person centered planning approaches available, including specific models of Essential Life Style Planning, Personal Futures Planning, MAPS, Planning for Alternative Tomorrows with Hope (PATH), Wraparound, or a generic approach to planning that contains all the required elements of person centered planning. It is not a requirement that any specific model is used, however, the approach should be reflective of the specific needs of the individual. In the case of a child, the approach should be reflective of the needs of the child and family within a system of care.
2. Identification of individuals and information needed to complete the planning process. Those individuals identified to participate will comprise the "planning team" or in the case of a child, a Child and Family Team.
3. Goals, desires and topics that the individual wishes to discuss.
4. Topics that the individual does not want discussed in a planning meeting.
5. Where and when the meeting will be held.
6. Potential issues of health and safety are identified, as well as supports to address them.

Following the meeting or meetings of the planning team or Child and Family Team, the clinician or case manager recommends services and supports that will accomplish the outcomes desired. Determination is made with the individual/family as to which of those recommended services, supports (including natural supports) and treatments are desired to meet the initial identified needs and life outcomes. The professional determines the amount and duration of care necessary to achieve the outcomes and includes the family/consumer in this discussion. An Authorization request is then submitted to the LME outlining the services and supports, as well as amount and duration needed. The person centered plan is then authorized by Utilization Management of the LME.

7.4.2.1 Required Content for Documentation

Regardless of the method of planning used, every plan must include the following elements:

1. Individual needs, preferences, and outcomes as identified by the individual and/or family.
2. Information obtained in the diagnostic assessment.
3. Potential issues of health and safety and services and supports to address these issues.
4. A proactive as well as reactive crisis contingency plan. Careful crisis planning should prevent over reliance on the crisis system; any use of the crisis system once the person-centered plan is developed should be a planned event.
5. Desired priority goals and measurable objectives expressed by the individual.
6. Strategies, activities, supports, services, and/or treatment to achieve goals and objectives including frequency and duration. During this process a thorough consideration must be made of the individual's resources, as well as natural and community supports. All resources must be included within the plan. Potential resources must be addressed in the following order:
 - a. Individual resources
 - b. Family, friends, guardians, and others
 - c. Resources in the community
 - d. Publicly funded services/supports for all citizens
 - e. Publicly funded services/supports through MH/DD/SA Specialty System.
7. Individuals responsible for completing or following through with activities, strategies, supports, services and/or treatment.
8. Signature of the consumer to acknowledge agreement with the documented elements of the plan
9. Documentation of any areas of disagreement and the steps to address the appeals process
10. Evidence of ongoing review and updating to reflect changes in life goals, circumstances, supports or services
11. Integration of goals, objectives, services and supports arising from other additional assessments or services that may be provided following the initial planning process

7.5 Indicators of Person Centered Planning Implementation

Compliance with the requirement for person centered planning can be shown by systemic and individual level indicators that demonstrate that person-centered planning has occurred. Methods of gathering information or evidence regarding person centered planning compliance may vary, and include the review of administrative documents, clinical policy and guidelines, case record review and interviews with individuals and families.

7.5.1 Systemic Indicators

Systemic indicators would include but not be limited to:

1. Evidence of a policy or practice guideline that delineates how person centered planning will be implemented.
2. Evidence that all tools used at screening or assessment reflect person centered philosophy and thinking.
3. Evidence that individuals/families are informed of their right to person centered planning and associated appeal mechanisms that complaints in this area are investigated and outcomes documented.
4. Evidence that the quality improvement system actively seeks feedback from individuals receiving services, support and /or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choice.
5. Evidence that staff development plans include efforts to ensure that staff involved in managing, planning and delivering support and/or treatment services are trained in the philosophy and methods of person centered planning.
6. Evidence that the quality improvement system includes processes for continual improvement of the quality of person-centered planning and that plans meet the essential elements.

7.5.2 Individual Indicators

Individual indicators would include, but not be limited to:

1. Evidence the individual/family was provided with information of his/her right to person-centered planning.
2. Evidence that the individual/family has choice as to what topics are discussed, or not discussed in any meetings, as well as who will be present and/or involved during planning meetings. There should be further evidence that those individuals identified to be involved were included in the planning and implementation process.
3. Evidence that the individual/family had informed choice in the selection of treatment providers or support services provided including staff that will assist in carrying out the activities of the plan.
4. Evidence that the individual's/family's preferences and choices were considered and implemented, or a description of the dispute/appeal process and the resulting outcome.
5. Evidence that the progress was made toward the valued outcomes identified by the individual and was reviewed and discussed for the purpose of modifying the strategies and techniques employed to achieve these outcomes.